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Is HIV/AIDS a disease of poverty?

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Abstract

HIV/AIDS is a global pandemic. From the biomedical perspective, HIV is a virus. HIV stands for Human Immunodeficiency Virus. The virus attacks the immune system, and weakens the body's ability to fight infection and disease. In recent years, the participation of anthropology in health research has been increasing. Especially, in the 1980s anthropologists were drawn the AIDS programme to make catalogue cultural practices that might carry the risk of HIV transmission. By an anthropological perspective, the HIV/AIDS epidemic is caused by poverty, starvation and hunger, war, unemployment, uneven regional development, sex traffic, migration and working away from home, prostitution and selling sex, drug transactions, and discrimination. This work considers the way in which poverty affects the HIV/AIDS epidemic, and the causes of spreading HIV pandemic are not just evaluated by poverty, also is evaluated considering by wealth.

Introduction

Critical medical anthropology seeks to understand health and disease from a holistic biological, sociocultural and political economic point of view that works against the dominant reductive orientation. This approach attempts to identify and understand determinant interconnections between one or more health conditions, community approach to the disease and social, political and economic conditions that may contribute to the development of patient health (Baer et al., 2003; Duyar, 2006). In recent years, the participation of Anthropology in health research has been increasing (Singer, 1994). Especially, in the 1980s anthropologists were drawn the AIDS programme to make catalogue cultural practices that might carry the risk of HIV transmission (Marshall and Bennett, 1990). Since then, anthropology has developed a more prominent point of view by advocating an approach to culturally specific behaviours and beliefs related to HIV/AIDS (Gatter, 1995).

There is no HIV treatment, but anti-HIV drugs (antiretrovirals) or AIDS symptoms are the treatments used to ensure that most people carrying the virus live a long and healthy life. The last stage of HIV infection, in which the body can no longer fight with life-threatening infections, is AIDS (Birchal, 1992). From an epidemiological perspective, HIV/AIDS is a behaviour-related disease spreading by behaviour that is at risk of HIV infection. It can be prevented if those risky behaviours, such as the common use of injection needles and unprotected sexual relations are avoided (United Nations, 2002). By an anthropological perspective, the HIV/AIDS epidemic is caused by poverty, starvation and hunger, war, unemployment, uneven regional development, sex traffic, migration and working away from home, prostitution and selling sex, drug transactions, and discrimination (Aggleton, 1992). AIDS, which is now in every nation in the world, is best described as a pandemic in this sense. In addition, it has spread to people of every age, gender, ethnicity, race, class, sexual orientation and religion. However, another useful term in thinking about AIDS is syndemic in that AIDS is best understood in light of its bio-cultural and political economic contexts (Baer et al., 2003). By this approaches, this work will argue that HIV/AIDS is a disease of poverty. In order to do so this work will discuss the ways in which poverty influences the HIV/AIDS pandemic, particularly in the developing world. In this way, the work will look to the biomedical literature this will be supported by ethnographic examples written by anthropologists.

Poverty and HIV/AIDS

The United Nations Joint Programme on HIV/AIDS (UNAIDS) explained that "poverty, underdevelopment, the lack of choices and the inability to determine one's own destiny fuel the HIV epidemic" (UNAIDS, 2008). Similarly, The World Bank's 1997 report *Confronting AIDS* states that the inequality in the distribution of income and common poverty seems to encourage the spread of HIV. (The World Bank, 1997). Hereby, as Hickel (2012) says "inequalities kill." Afterward Schoepf (2001) says that, poverty, impotence and stigmatization promotes global disparities in class, gender, and ethnicity as it encourages the spread of HIV. It is a long time that scholars believe there is a strong relationship between poverty and human virus (HIV) epidemic. So, nowadays it's known that there is a strong connection between poverty and communicable disease such as HIV (Nattrass, 2009).

In 2004, in an article published in the *Lancet,* Fenton reviewed the way in which poverty influences people with so called 'high risk' sexual behaviour (Fenton, 2004). She argued that poverty is a strong link between low socioeconomic status and HIV. Also she says (Fenton, 2004) in communities with general epidemics, everyone should be informed about the prevention of epidemics and interventions. Then concludes that the only long-term response to the epidemic may be poverty reduction (Fenton, 2004).

In a biological context, poverty leads to lack of access to adequate food and hence, malnutrition. Malnourishment can greatly compromise a human's immune system, making it more susceptible to infectious diseases such as HIV/AIDS. Health economist Eileen Stillwaggon argued that the prevalence of HIV is highly correlated with decreased protein consumption, falling calorie consumption, inequality in income distribution, and infectious disease variables (Stillwaggon, 2006).

Stillwaggon focuses on malnutrition and lack of access to health care among the poor. She suggests that these factors affect "epithelial integrity" and "immunity," and raise the possibility of having other untreated sexually transmitted infections. All above mentioned factors can increase susceptibility to HIV infection.

Poverty is also tied to the lack of education, and illiteracy. This can be a reason to ignore or misunderstand the messages regarding risk and prevention. For instances, research has shown some people believe that condom sold in local shops are not effective enough because they are believed to contain microscopic holes that are too small to see but large enough for sperm and HIV to get through (Pulerwitz et al., 2006). In a research conducted in Kenya one participant explained his concern in this way "I understand that there are faulty condoms with holes which viruses can pass and thus causes infection" (Pulerwitz et al., 2006). Also In 2000 and 2004 UNAIDS report confirmed that in many rural areas of Africa people rejected condom use (UNAIDS, 2000, 2004). In addition reduction in pleasure is one of the most common reasons given for failing to using condoms (Gilmore et al., 1994). According to research many adult, both male and female express the belief that requesting a partner use of condom shows a lack of trust and suspicion in the partner and they would not use a condom with a partner that they trusted (Gillmore et al., 1994; Pulerwitz et al., 2006). Based on research among women conducted in Kenya, fear of physical repercussion was an issue in the use of condom by men (Pulerwitz et al., 2006).

UNAIDS confirms one problem around condom use is a lack of knowledge of the value of condoms in combatting HIV/AIDS, method of using condoms correctly to reduce the danger of breakage or slippage especially in rural areas where people are living in poverty and there is no access to public health (UNAIDS, 2000, 2004). Even with knowledge of the risks, the cost of prevention may be too high; many people in low income countries are not able to afford condoms. However, the virus causes HIV; many scholars believe (e.g., Lakdawalla et al., 2006) that 'high risk' sexual behaviours increase HIV prevalence. According to the World Health Organization (WHO) and UNAIDS those 'high risk' sexual behaviours such as selling sex and cross generational sex are directly related to poor economic conditions.

In some parts of the world with great social instability and poverty throughout most of their history such as Africa, HIV/AIDS continues to spread. The economic and political crisis in most African countries is increasing unemployment among people. When the area of work is narrowed, women are usually the first to be fired. Without jobs women have no money, which forces women to find other ways to support their families. There are few ways for women to find work and make money, so many of these women are turn or forced to exchanging sex for money as a solution (Sanders, 2005). An example of 'high risk' sexual behaviour is cross generational sex or "sugar daddy syndrome." Cross generational sex is recognized as one the most important factors in the speared of HIV/AIDS globally (Hallett et al., 2007). Many researchers (Smith, 2002; Ailio et al., 2011; Quinn and Overbaugh, 2005) have identified that gender, age and poverty are three contributory factors in increasing dangerous sexual behaviours which reduce women's ability to control her sexual behaviour through affecting the power balance between the sexes and therefore affecting decision-making.

In Zimbabwe it has been shown that substantial age difference between sexual partners is a major behavioural determinant in the rapid raise of HIV/AIDS prevalence in young women (Mahomva et al., 2006). According to the Interagency Gender Working Group (IGWG, 2018)

cross generational sex is a pattern of sexual behaviour between young women and much older men that results in increased health risk. In most cases the young women are unmarried and between 15 and 19 years of age, whereas their male partners are at least 10 years older. One of the main reasons for this phenomenon is the economic factors. Although some girls engage in such relationship voluntarily, other girls form such a relationship against their will, because of economic insecurity. This has been described as "economically rational sex." Young women from poor families start a relationship with an older man in order to secure their basic economic needs, such as food, housing, school fees, shoes and school uniform. Although poor women are generally aware of AIDS, they do not have the option to earn money to survive and support their families. Boys can also be obliged to have relation with an older partner, due to extreme poverty and because the older partner gives them money or allows them to settle in their home (Cohen and Tate, 2006).

Poverty may work through different ways to increase HIV prevalence. For instance, social, economic factors may push some people to leave their home town in order to find a job in other cities or even in a different country. Migration itself may provide some side effects, including familiar social and cultural norms, families and spouses, language barriers, sub-standard living conditions and detachment from exploitative working conditions. The resulting isolation and stress can cause migrant workers to take part in insecure temporary situations or commercial sex that increase the risk of HIV. This risk is further increased by the fear of stigmatization in asking for information about HIV and inability to access HIV services or to support female migrant workers. Many of the female migrants are hired for jobs that they don't need any special skills such as manufacturing, domestic service or entertainment sectors and bars. They usually work without legal status and have little access to health services. They are often at risk of exploitation or risk of physical and sexual violence by employers and there are very few alternative employment opportunities. Women left behind by their spouses, also face economic challenges, and other related problems such as food insecurity that is directly linked to their husband's migration. These women may be forced to exchange sex for food or money and it makes them thus vulnerable to HIV. They may be at risk if their husband returns infected with HIV (Mweru, 2008; Deane et al., 2010).

How about men in this case? Lurie et al. (2003) argue that migration is an independent risk factor for HIV infection in men. They argue that it is not just immigration that increases vulnerability to HIV/AIDS, migration process and structure are effective. For example, Lurie et al. (2003) show that about 62% of adult males in KwaZulu-Natal Hlabisa keep most nights away from their rural houses and their wives. Wilson (2006) conceptualizes the relationship between apartheid (racism in South Africa) and HIV by pointing out the vicious circle of young men to get away from their families, turning their lives into gloomy and difficult, encouraging alcohol abuse and exposing them to abuse sex in hostels. He concludes his idea that the HIV epidemic in South Africa is feeding from these seeds today.

Case studies

AIDS is a disease of modernity in communities struggling against inequality, poverty, war and economic crisis. Many people who know the risk of sexually transmitted infections, especially many women cannot avoid being sick, since they cannot control the power relations that endanger their lives. Pandemic is more than a series of personal and family tragedies (Schoepf, 2001).

Philip Setel's work, *A Plague of Paradoxes: AIDS, Culture and Demography in Northern Tanzania* (1999) clearly shows how poverty impacts on the HIV epidemic. In his work Setel shows how social factors influence the transmission of the HIV virus. In Tanzania, colonization was followed by new economic opportunities such as coffee production; this changed the

traditional forms of agriculture by Chagga families. After World War II, the fast population growth led to emigration, especially by young single men. Those men who naturally needed sexual contacts but who were not able to marry until they had gathered the resources needed to acquire a wife. In this case, when HIV first became visible it was related to the men who were travelling for their business. The disease spread fast, as Setel notes, "In 1992, Kilimanjaro was listed as the seventh most severely affected region, with 134.2 cases per 100,000; in 1994, the fifth; and in 1997 the third. In 1991, over 70% of self-identified prostitutes tested seropositive" (Setel, 1999). In his work Setel (1999) discusses the high level of HIV infection among women as a result of both their economic and social subordination as much as of their sexuality. He argues the women's impoverished lives and economic insecurity, led to different forms of prostitution and selling of sex. On the other hand the women had not enough rights against male powers in their sexual relationship so that they could not ask their partner (both boyfriend and husband) to wear a condom. Even though many women knew about their partners HIV risk and wanted to protect themselves, as respectful wives or because of the fear of losing their money recourse they could not make such a suggestion to their partners. The men who were travelling to find a job and avoid wearing condom in their sexual relationship and the women financial insecurity that pushed them to selling sex led to high prevalence of HIV in Tanzania. Thus, as Setel (1999) argues, the necessity of the men to travel for their economic livelihoods, the women's lack of agency in dealing with their husbands and partners and also their move into selling sex can all be seen as a result of the poverty in which they live. Setel's study clearly shows how poverty followed by migration to find a job can catalyse HIV/AIDS epidemic and also it shows HIV control and prevention programs must also aim to raise the social status and economic security of women if they are to be successful.

Mweru in her qualitative study (2008) of HIV and women who immigrate to other places to find a job in Kenya has argued that poverty pushes many women to leave the rural area to find jobs in other cities. Mweru's study shows that, from the young women's perspective, the need to have a job is more important than the risk of being infected with HIV. Therefore these young women migrants felt they had little power to refuse sex with their employers. Mweru argues low income levels are the most important factor contributing to young women's inability to negotiate sexual practice with their supervisors. These women have to send their income to their families so they are scared that if they attempt to discuss the subject of sexually transmitted diseases with the men they could lose their job. Also, as they need to save any income for their families they may start a sexual relationship with these men who have a house so that they can stay in a house without paying rent. The women's need to find a home followed by a sexual relationship with the house owner make them vulnerable to infection with HIV/AIDS and also other STDs. In this case poverty pushes the women into unequal and unsafe sexual relationships with men such as their employers or landlords in order to secure accommodation and work (Mweru, 2008).

As the studies by Setel (1999) in Tanzania and Mweru (2008) in Kenya show, poverty and inequality go hand in hand. The condition becomes even worse when poverty is tied to other social factors such as political dislocation and can drive the HIV/AIDS epidemic even faster. Paul Farmer's work of Haiti (1992) is an example of this. In his work he focuses on the Peligre basin of Haiti's central Plateau where several hundred thousand mostly rural poor people are living near Artibonite River. Before 1956, the village was fertile and people's income came from selling rice, bananas, millet and corn. However, in 1956, with the construction of Haiti's' largest hydroelectric dam on the river many people were displaced because of flooding. These people moved to the hills near the river and dived into two groups "Do and Kay" that both parts were poor. The first three cases of HIV in Do Kay were those who had attempted to escape the poverty of Do Kay by moving to Port-au-Prince. Farmer argues that risk of being infected with HIV was associated with one's occupation or partner's occupation. For example, being in a sexual relationship with soldiers and truck drivers had a much higher risk of acquiring

HIV than being in a sexual relationship with a peasant farmer. In fact, in the region's economic crisis, the gap between the hungry peasant class and salaried soldiers and truck drivers who were not from rural population made a local context of inequality. Marriage and a sexual relationship with the salaried soldiers and truck drivers who were paid on daily basis were actually a strategy for the poor women to protect themselves against poverty. The women often partnering with men from these occupations are a desperate attempt to escape poverty. The condition followed by gender inequality that restricts women's negotiating power in sexual relationship, political upheaval, lack of access to treatment for STDs, lack of culturally appropriate preservation tools, and lack of timely response by public health authorities. Therefore, the HIV/AIDS epidemic spread among rural Haitian.

Poverty also means that there is not enough money or money to support health care programs and treatments. Since there is no money for health care and treatment, there is no money available to get vaccines and medicines used to reduce the spread of AIDS. In his work of HIV/AIDS in West Africa, Nguyen (2010) explains how poverty and lack of funding to support treatments limit access to medications so that an important HIV/AIDS programme which was defined by UNAIDS broke up. As Nguyen describes in 1998, the first programme in Africa that sought to provide the general population with access to medication was a joint programme between the Ivoirian Ministry of Health and the UNAIDS. It was a pilot programme to improve access to the medications. In order to provide the medication for all the patients UNAIDS hired an Irish consulting firm with a close tie to pharmaceuticals industries to reduce the medications' price. The Ivorian government pledged one million dollars to a drug purchasing fund and subsidized the medications. The programme started in late of 1998 and people who were eligible to receive the medication must take an adequate dosage of the anti-viral drug three times per day. Soon after, the programme organizers realized that reducing the medication price and subsidizing were insufficient for the patients who were struggling with poverty. While the other patients could not get the recommended three drug cocktails for more than a few months, the patients who continued the treatment could get only two drug cocktails. Consequently, the majority became resistant to the anti-viral treatment and the virus speared among them quickly (Nguyen, 2010).

Nguyen's work clearly shows for the people who are living in the structural poverty even reducing and subsidizing the medications price may bring an opposite result and fuel the epidemic among people. Nguyen (2010) argues the lack of financial support for the medications and HIV testing created a system of triage among people. This means all the people who were eligible to receive medications and testing could not benefit from these facilities that are usually provided by NGOs and governmental organization. The NGOs that chose the person who was eligible to receive the treatment and testing. Lack of resources pushed the NGOs and other related organization to ignore some the patients and people who are at risk so that many people could not access to free condom, treatment and sexual counselling. Those HIV positive people who left without any access to treatment and testing facilities are still in sexual contacts with their partners. This allowed the epidemic to spread among West Africans.

According to Nguyen (2010) poverty often leads to a system of triage to distribute the resources. Triage is a system that military physicians should decide who can be saved and who cannot be saved among the wounded during the war and who can benefit most from the medication and treatment. Nguyen states that access to treatment, based on the ability to benefit from social relationships and social networks, defines a triage system. It is obvious that making such social relations and connection is not possible for all the patients and high risk groups. Furthermore, those NGOs and organizations often prefer to choose the patients that can bring some benefits for them. NGOs preferred to choose those patients who can facilitate the NGO's work, for example as a customer officer. Nguyen's work clearly shows in case of lack of resources and poverty, access to treatment and testing will be limited only for a minority of the patients/ high risk groups and rest of the population who are living in a given society, have

no access to the resources which are necessary to prevent and control a pandemic among people.

Effect of wealth

While many studies consider poverty as a social factor that catalyse spreading HIV/AIDS among people in different countries, the idea that poverty causes the spread of HIV has been challenged by some other studies based on the correlations of epidemiological and socioeconomic statistical data. These studies explain that in many African countries, the prevalence of HIV infection is directly related to wealth rather than poverty. For example, Shelton et al. (2005), the epidemiologist argued, there is a strong relationship between human welfare levels and the prevalence of HIV infection in the United Republic of Tanzania. The epidemiologist, Chin (2007) who collected his data from Kenya, also revealed that national HIV prevalence rates were directly related to national income in Sub-Saharan Africa until 2000 (Chin, 2007). In another study conducted by Mishra et al. (2007), he considers HIV infection prevalence by wealth group with national survey data for eight African countries (Burkina Faso, Cameroon, Ghana, Kenya, Lesotho, Malawi, the United Republic of Tanzania and Uganda). Mishra et al. (2007) showed that there is a positive relationship between the economic status of households and HIV prevalence.

By considering these studies the question that appears, is it poverty or wealth that drives HIV/AIDS infection prevalence among people? In order to achieve a better understanding of this concept it is appropriate to look at the former executive director of UNAIDS's argument. Peter Piot et al. (2007) responds to this question as follows; HIV infection rates in African countries are not only related to wealth, but also to income inequality. In fact, income inequality makes a suitable context for high risk sexual behaviour in two different sides: who has the money and who has not enough money, for instance, in terms of cross generational sex. Many of the men who start a sexual relationship with a very younger girl believe that their sexual life was not enjoyable when they were young and they want to experience the effect that their newly-found power, associated with their money and possessions, has on their sexual life.

Conclusion

This work has shown the multiple ways that the HIV/AIDS pandemic is fuelled by poverty and inequality and, can therefore, is called a disease of poverty. To illustrate this point this work has drawn on a number of anthropologists and epidemiologists.

It is obvious that poverty catalyse spreading the infection among people. Women's lack of agency with regard to sexual liaisons and the need to engage in sex for money of other benefits his one of the ways in which the HIV/AIDS pandemic is fuelled by poverty and inequality as illustrated in the studies by Setel (1999), and Mweru (2008) discussed in this study. Poverty usually is linked to malnutrition which is one of the main factors to make the body weak against infection especially in children and women who are pregnant. Poverty also has strong ties with lack of access to education and literacy among people. In a society where people have no access to education due to poverty, the HIV prevention programmes and also the prevention methods maybe misunderstood by people who have not enough knowledge.

Poverty also has a heavy impact on access to treatment, health services and condom which is necessary to prevent the spread of infection among high risk groups. Additionally, poverty may create high risk sexual behaviour pattern such as cross generational sex, especially among women who have not enough skills to find a job. Therefore, they start a sexual relationship with the men who can provide their basic economic needs.

As the study by Mweru (2008) discussed, poverty may lead to migration to find a secure job for both men and women. This condition makes a suitable context for spreading HIV/AIDS in different ways. As Nguyen's (2010) study showed, poverty also means that there is little or no funding for supporting the health care programs and treatments. When there are not enough resources of medication and testing and prevention facilities a system of triage may create among the organization and NGOs which have the responsibility to distribute the resources among people so that many patents and high risk groups may ignore and leave behind by the organization and they cannot access to prevention facilities and testing. These ignored groups have the potential to transfer HIV to others. There are also some arguments that consider wealth as a factor to boost HIV infection among people. However most of them are emphasis of income inequality rather than wealth itself. In conclusion, drawing on the work of several researchers this work has demonstrated how HIV/AIDS cannot be seen as anything other than a disease firmly associated with the social, political and economic context in which it thrives. In other words, HIV/AIDS is a disease of poverty.

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